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ARTICLE

Teaching medicine of the person to medical students during the beginning of their clerkships

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Abstract

This article describes how medicine of the person is taught to 4th year medical students in Groningen, The Netherlands, as part of the teaching programme 'Professional Development'. In that year, the students start with their clerkships. In this transitional phase from medical student to young doctor, issues of professional identity are raised. It is an intense period with feelings of uncertainty and overwhelming experiences. Therefore, parallel to the clerkships we have organised 28 meetings of 2 hours with extra time dedicated to reflection and learning. These groups consist of 10-12 students with a rotating student chair under supervision of an experienced teacher, or, "coach". We focus on personal and professional development by reflecting on work-based experiences. In the first hour the students discuss in a structured way a critical incident experienced by one of them. Learning experiences include personal learning (as emotions), skills (as empathy development) and professional learning (discovering the profession). In the second hour the students discuss set medical-ethical dilemmas. The coach facilitates the group discussion and oversees the group dynamics. During the year, the students work on their portfolio including writing a personal development plan. In 3 individual interviews with the coach this plan is monitored. In the final interview the students are assessed by their coach on their professional development during the year. In this paper we present the results of the evaluation of this programme 'Professional Development' by the students and The Netherlands Association for Medical Education.

Keywords

Clinical clerkship, medical students, peer group, professional competence, social values, undergraduate medical education

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Introduction

At the University of Groningen in The Netherlands, we teach medicine of the person to fourth year medical students within the teaching programme 'Professional Development' [1,2]. By reflecting on their behaviour, the students learn to discern their values and how these values influence the relationship with patients and colleagues. In this article, we will discuss the teaching philosophy of our medical school, the curriculum design and more extensively the contents and organisation of the programme 'Professional Development'. We will conclude with an evaluation of this programme by students and teachers.

Teaching philosophy

The medical school of Groningen is one of 8 medical schools in The Netherlands. Since 2003, we have

integrated the 7 professional roles of the doctor in our undergraduate curriculum in teaching as well as assessments [3]. These roles were the results of an extensive study some decades ago by the Canadian Royal College of Physicians and Surgeons of Canada among colleges and healthcare providers, dealing with what makes a good doctor. Many medical schools around the world have incorporated them into their undergraduate and graduate curriculum. The following roles of a medical doctor emerged from the CanMEDS study [3]: the medical doctor as a medical expert, communicator, collaborator, manager, health advocate, scholar and professional. For teaching purposes, the professional roles have been defined as competencies. A competency consists of knowledge + skills + attitude. In our programme 'Professional development' we mainly focus on development of 4 of these 7 competencies: the competency of being an effective communicator, collaborator, health advocate and professional.

Curriculum design

Since 2006, we have delivered professional development programmes within the first 5 years of our 6-year medical degree. Yet, practical aspects of medicine of the person are most clearly visible in the fourth year. Medicine of the Person gives account of the need to integrate the scientific basis of healthcare more fully with spiritual, religious and ethical values. It supports a medical practice which takes account of personal relations, spirituality, ethics and theology [4]. In this, it builds on the ideas and beliefs of Paul Tournier, an influential Swiss general practitioner whose thinking has had a substantial impact on routine patient care relevant to national health services.

The importance of professional development for medical students is obvious in at least 2 areas. The first argument is that unprofessional behaviour in medical school is associated with unprofessional behaviour later in professional practice [5]. The second argument is that professional development includes reflecting on the knowledge, skills and attitude necessary to develop skills for self-directed, lifelong learning in the doctor's future professional career.

Organisation and design teaching programme 'Professional Development'

Our programme "Professional Development" is given throughout the fourth year. Every student takes part in 4 blocks of 10 weeks. Every 6 weeks, new groups of students start, so it is a rotating programme. Every year, there is an intake of 425. One block consists of 5 weeks skills training in preparation for the clerkships, followed by 5 weeks of clerkships on one of the wards or outpatient clinics in a teaching hospital. Throughout the year, the students meet with their peers and the coach, who is an experienced teacher. We have scheduled 28 meetings of 2 hours, including 23 group meetings with pre-arranged topics on medical-ethical dilemmas, 2 meetings with a topic to be chosen by the students and 3 personal meetings with the coach. Each group consists of 10-12 students with a rotating student chair (Figure 1).

The coach has a facilitating and supervising role, not a teaching role. Since the peer group meetings are all on Wednesday afternoons and coaches supervise a maximum of 2 groups, we employ between 25 and 30 coaches.

Peer group meetings

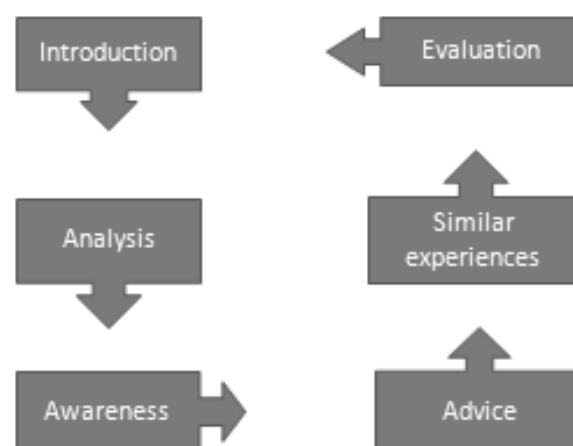
The peer group meetings are dedicated to reflection and learning [6]. In the first 2 group meetings, agreements are set for the peer group such as confidentiality, willingness to learn, preparation, commitment and attendance. Time is set apart for participants to get to know each other. The first hour of every meeting includes peer group mentoring,

the second hour includes discussing set topics. We use the peer mentoring model of Hendriksen (Figure 2) [7].

Figure 1 A peer group of 4th year medical students (2012) with their coach



Figure 2 The peer mentoring model used in the teaching programme 'Professional development'



In the introduction, the student chair returns to the last meeting to inquire about the developments in the case brought forward by one of the students. Then, every student reports about his/her experiences of the last week, finishing by the group selecting a case to discuss. Topics of peer mentoring include personal and professional values, such as the use of empathy (Figure 3) [8].

Sometimes, spiritual or religious issues were discussed, either in the personal interviews with the coach, during the peer mentoring process or in the peer group consultation meetings for coaches (Box 1).

Once the suggested case of the student is selected, the other students ask clarifying questions to the presenting student: 'What did you want? What did you think? What did you feel? What did you do?', combined with 'What did the other persons want, think, feel and do?' After these questions, the contributing student is more aware of his real question and might be able to reformulate it. Only after these analysis and awareness phases do other students suggest other approaches and give advice and possible solutions. The contributing student picks out an appropriate piece of advice to implement in the coming

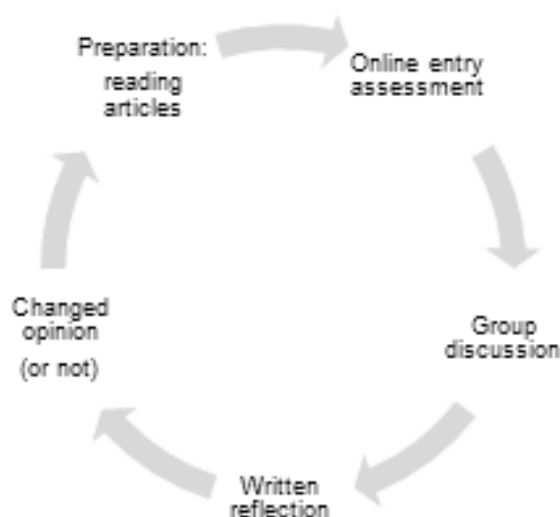
Figure 3 Topics of peer mentoring



week. Next, the students are stimulated to bring in similar experiences. We finish this peer mentoring hour with an evaluation of the group process by the students as well as the coach. In this way students learn how to grow in their new professional roles and learn to discover and formulate their values.

In the second hour, the students discuss a pre-arranged topic which has been prepared at home. Examples of topics are cultural differences, death and dying, obesity, corporality, loyalty and collegiality, sexual harassment, patient-centeredness, the sick doctor and medicalization. Here, we practice the lifelong learning cycle (Figure 4).

Figure 4 Lifelong learning cycle used in reflection of prefixed topics



In advance of the group meeting, the students have read selected articles to prepare for the topic discussion and complete an online entry assessment. During the group discussion the students compare their views with their peers. Afterwards, they write a reflection on the development of their views which might have been changed by the articles or the group discussion. The student chair prepares the discussion and is free to use a quiz, to formulate statements to discuss, to give a presentation on the topic or to show a YouTube film from the internet.

Two of the group meetings are without a topic and the students are encouraged to organise their own meeting focused on team building. In the past, students have chosen to watch a medical film, visit a hospice, invite a speaker, share a meal, or to go sailing or skating together.

The third type of meetings are the 3 personal interviews with the coach. The goal of these personal interviews is to monitor the individual student's personal and professional development. In the introductory interview, the coach asks questions such as 'How does your white coat feel?' and 'How is the balance between your private and professional life?' The mid-year progress interview is a more formal interview where the first version of the student's portfolio is being discussed along with the student's obligations concerning attendance and group discussions. In the final assessment interview at the end of the year, the definite portfolio is being assessed, together with questions from the coach such as 'Have you changed as a doctor and a person during this year?' and 'Which characteristics of a doctor are important to you?'

Box 1 Examples of spiritual or religious issues discussed with students

I. Source of inspiration

During the introductory interview with the coach, a female student talked about the interruption of her studies for half a year just a few months ago. At that time, she felt overworked and had problems in dealing with her studies. In that period she slept a lot, reflected on her life and finally regained resilience again. Now, while having just finished the first of her 4 clerkships, she pondered what her source of inspiration was. She said she needed to know this, because otherwise she might not be able to complete all her clerkships successfully and could get overworked again. She described this source of inspiration as a lifestyle, method or place which when applied would give her new strength and energy. The coach advised her to bring this topic in as a point for peer group mentoring. To discuss the source of inspiration for each of the students might bring awareness of the spiritual need of every human being to 'drink from the brook by the way; therefore he will lift up his head' (Psalm 110:7).

II. Purpose in (professional) life

A male student in a students' peer group half-way in his 2nd clerkship revealed with his feelings of redundancy or needlessness when approaching patients, for example, administering an infusion. His central question was: What can I in essence really do for a patient? This feeling was getting more problematic the last few weeks. After he was questioned by his peers, he re-formulated his point with the following questions:

- What is my goal as a clerk? To learn only technical skills is not enough for me.
- In what way can I be significant for the patient?
- I want to be myself, I don't want to copy my supervisor, I want to be authentic.

Others students gave him advice:

- Ask how the patient is doing and listen to the story told.
- Simply administering an infusion is also meaningful because it helps the patient to regain health again.
- Go ahead with your studies and finish it; as a doctor you will be able to mean more for the patient than as a student

Other students shared similar experiences. However, they did not feel this need as painful as the male student did.

At the end of the peer group meeting, the coach evaluated with the following points:

- She praised the student's courage for formulating his (at first) indefinable and vague feeling of unfulfilled desires.
- She highlighted the transformation of the interpretation of his feelings from uncertain to more defined ('lack of purpose' and 'want to be authentic').
- She emphasized that the urge to give meaning to someone's life is a strong internal thrive.
- She confirmed that the student's high goals were totally licit. To look for meaning and the longing to want to be authentic are essential values in his professional life.

III. Religious beliefs in the doctor-patient relationship

In one of the peer group consultation meetings for coaches, one of the coaches told the next story.

In his latest students' peer group, he had found out that a Christian student was too afraid to express her Christian values around the topic of euthanasia. This happened when, after a discussion on euthanasia, this group as a whole decided to be in favour of euthanasia. The Christian student kept quiet. Yet, the coach wondered if this Christian student had difficulties with this view. In the first peer group meeting she had introduced herself as a Christian with a Christian lifestyle. Also, during the discussion in the peer group, the coach also had observed her non-verbal body language, including nervously moving hands and her red face giving away her real conviction. Therefore, during the final interview with the student, the coach formulated the discrepancy he had observed between her Christian beliefs and her attitude in the peer group meetings. She affirmed this and told the coach she was afraid for the judgments of the group when she expressed her religious faith as the reason for being against euthanasia.

In the peer group consultation meetings for coaches, the coach said that, in future peer groups, he would ask his students explicitly if and how religious beliefs could be the basis for attitudes and actions in their doctor-patient relationships. He suggested the peer group meeting on 'cultural differences' would be the most appropriate method to do this.

The coach

The coach has a facilitating role and observes and mentors the group process. The coach monitors the safety within the group and tries to deepen the discussion by encouraging reflection skills. Sometimes, the coach raises awareness about what is going on in the peer group (Box 2).

Box 2 Example of the role of the coach: bringing up awareness of students' behaviour in the peer group

One of the coaches felt disturbed by the use of certain language of the students during several peer group meetings. She formulated this during the group evaluation by saying that the use of four-letter words/sexual words, religious word and diseases as a term of abuse distracted her from what the students really wanted to say. This made the students sit up; some were surprised or shocked as they were not aware of the impact of their language use. Some felt ashamed, but others said they show this behaviour only among other healthcare professionals, not when patients were present. In conclusion, the coach made the students aware and discuss about their behavior and the impact of it on others.

Our coaches are faculty, but not necessary with a medical background. Some have backgrounds as ethicists, theologians and psychologists. One thing the coaches have in common, is that they are not involved with the departmentally-based clerkship activities. This guarantees splitting the role of facilitator outside the workplace and assessor at the workplace.

Once a month, the coaches also have their own peer group consultation meetings over lunch prior to the students' peer group meetings. Actually, the coaches form their own 'community of practice' [9]. They exchange experiences and give each other advice and support. So the same format is used for both coaches and students. A few times a year, workshops are organized for the coaches' continuing education. Previous topics were: how to facilitate small groups, critical incidents in a group, how to give feedback, setting and reaching goals for students.

Portfolio as assessment tool

During the last 2 personal interviews with the coach, the student's portfolio is assessed [10]. The portfolio includes personal data, reflection reports on peer group mentoring and the prefixed topics. The most important part of the portfolio is the personal development plan. The students answer 4 essential questions in a self-assessment: 1. How competent am I concerning the 7 competencies? (strengths and weakness analysis; Box 3), 2. What do I want to know or to do better? (personal learning goals; Box 4), 3. How do I reach my goals? (approach and resources) and 4. How can I make this growth visible? (proof).

By given a written account on the level of mastering the 7 competencies, the students are actively encouraged to

reflect on their skills, attitude and knowledge. As the examples in the Box 3 and Box 4 show, topics concerning values, the person of the doctor and the patient and the doctor-patient relationship, are expressed by the students in a natural way.

Box 3 Sentences taken from strong and weakness analyses of 7 students. In reality the written reflection of each competency comprehends half a page

<p>I. COMMUNICATION Sometimes I experience that I am too much at the same level as the patient, being more a neighbour than the doctor.</p> <p>II. PROBLEM SOLVING I find it difficult that I know too little on some topics. This is hard to manage for me, because I would like to know everything and want to understand some things down to the last detail.</p> <p>III. APPLYING KNOWLEDGE AND SCIENCE I used to look on websites like Wikipedia and from patients' associations. But now I realise I have to develop a habit of finding reviews and meta-analyses.</p> <p>IV. PATIENT EXAMINATION Physical examination is still awkward for me. I am not feeling very comfortable with it yet. I don't know what to look for.</p>	<p>V. PATIENT MANAGEMENT I am mastering this point right now. I did a class on alternative medicine and I am able to review critically medication use and our western way of practising medicine. I want to make the treatment patient-centred.</p> <p>VI. USING THE SOCIAL AND COMMUNITY CONTEXTS I think a good doctor needs to have a holistic view on his patient. Although I realise that doctors often have little time and are too much focused on their own speciality. I want to see the patient as a whole.</p> <p>VII. REFLECTION I am able to look critically at myself. I know I am a perfectionist. I am receptive for criticism from others, but I notice that I am more open for criticism from people whom I value highly.</p>
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Box 4 Some examples of students' general and personal learning goals as expressed in their portfolio

<p>General goals:</p> <ul style="list-style-type: none"> • I want to improve my skills such as to apply a drip, to stitch, to do a physical examination, to take a blood sample • I want to gain more ready knowledge <p>Personal goals:</p> <ul style="list-style-type: none"> • I want to know better what I want to do after my master • I want to have more time (in a responsible way) for relaxation • I want to be a more confident doctor: to dare to communicate when things do not go how I want it, to be able to defend myself during evaluations when I don't agree with the criticism. • I noticed during my clerkship I am changing like a chameleon in different social situations. I was shocked by it, because I want to be an authentic doctor.
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In this way, students learn to reflect and work on their own professional continuing education.

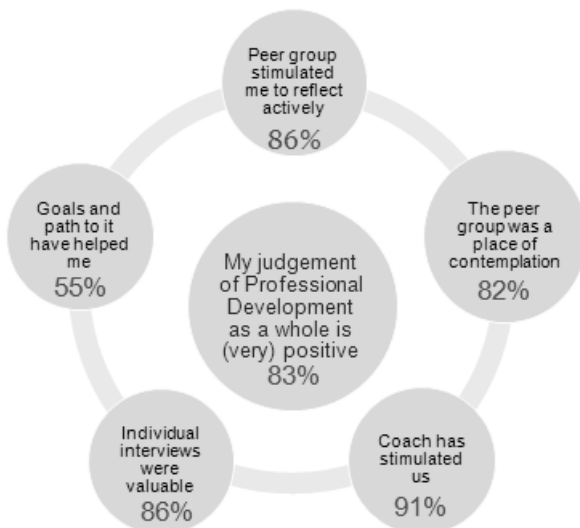
The coach informs the final examiner of the programme who has passed the module, this is a professor

who does not interfere with the on-going peer group meetings. Eventually only 1-2% of the students fail.

Evaluation by students and national teaching professionals

When a peer group has finished after a year, we evaluate our teaching programme 'Professional Development'. The 22 statements the students assess have 4 answers to choose from: fully agree, agree, disagree, fully disagree and the evaluation includes the goal of the programme, the peer group meetings, the portfolio, the coach, the assessment and the organisation and the students' opinion of the whole programme. In the course of the 6 years that we have delivered the programme, the results show a gradual improvement. For a summary of the results see Figure 5.

Figure 5 Percentage of students (n=67) who fully agree or agree with the statement during an evaluation in October 2011



In November 2011, our University received the Innovation Prize of The Netherlands Association for Medical Education for this programme 'Professional Development'.

The future

We continue with student groups with peer mentoring in the sixth and last year of medical study. We are curious if our teaching in professional development has a lasting effect on the behaviour of our students when they are actually doctors. Yet, collecting evidence to investigate this is not easy, because the professional behaviour of doctors is influenced by many different factors. At the time of writing, no follow-up studies have yet been planned.

Conclusion

Teaching professional development in small peer groups is an appropriate and effective method to teach medicine of the person. Medical students entering the medical workplace raise questions in a natural way about appropriate professional behaviour, including the person of the doctor with their values and attitudes towards the doctor-patient relationship. Small peer groups provide dedicated time and a stimulating atmosphere to explore and learn about professionalism. Mastering reflective skills will be profitable through the student's lifelong learning career.

Conflicts of interest

The authors report no conflicts of interest.

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